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ORIGINAL PAPER

Asylum Grant Rates Following Medical Evaluations of Maltreatment among Political Asylum Applicants in the United States

Stuart L. Lustig · Sarah Kureshi · Kevin L. Delucchi · Vincent Iacopino · Samantha C. Morse

Abstract Although many individuals applying for political asylum allege maltreatment and sometimes torture in their countries of origin, the utility of medical evaluations in asylum adjudication has not been documented. This study compares the asylum grant rate among US asylum seekers who received medical evaluations from Physicians for Human Rights (PHR), with rates among asylum seekers who did not receive PHR evaluations. Retrospective analysis was carried out on all asylum cases referred to PHR between 2000 and 2004 for medical evaluations for which adjudication outcome was available. Basic demographic information was obtained: age, sex, country of origin, English language ability, US region where adjudication occurred, whether legal representation was pro bono, type of evaluation, provision of oral court testimony, and whether asylum seekers were in detention. Cases were analyzed descriptively and with chi square tests. Between 2000 and 2004, 1663 asylum seekers received medical evaluations from PHR; the adjudication status (either granted or denied) was determined in 746 cases at the time of the study. Of these cases, 89% were granted asylum, compared to the national average of 37.5% among US asylum seekers who did not receive PHR evaluations. Medical evaluations may be critical in the adjudications of asylum cases when maltreatment is alleged.

Keywords Political asylum · Refugee health · Maltreatment · Immigration policy · Global health

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Introduction

Maltreatment and torture are practiced in more than half of the world's countries and have devastating physical, psychological, and social health consequences [1, 2]. Maltreatment may consist of robbery, rape, gang violence, physical or sexual harassment. Threats or brutal treatment from police or other government officials also constitutes maltreatment, which furthermore includes governmental indifference towards or tacit collusion with these incidents when perpetrated by civilians.

Asylum Legislation in the United States

Asylum may be granted in the United States to people who are unable or unwilling to return to their home country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion [3]. The US law relating to refugees and asylum is part of the general immigration law which is set forth in a multitude of

statutes, regulations, and administrative and court decisions and is enforced by officials of the Departments of Justice, State, Labor, and Homeland Security (DHS). US asylum law is based in part on international law. The United States is a signatory to the 1967 Protocol Relating to the Status of Refugees, and as such is bound by the provisions of the Protocol and the 1951 Convention Relating to the Status of Refugees. In 1980 the United States enacted the Refugee Act as part of the Immigration and Nationality Act in an attempt to conform to international standards, but later in 1996 passed the Illegal Immigration Reform and Immigrant Responsibility Act (the ''1996 law'') [4]. The 1996 law imposed a one-year filing deadline (known as ''the one-year bar'') on asylum applications and an expedited removal procedure on asylum seekers who arrive without valid travel documents.

Since the terrorist attacks of September 11, 2001, a heightened concern for national security has produced several changes that adversely affect the ability of asylum seekers, particularly those in detention, to obtain asylum, including: the expansion of the Attorney General's immigration detention authority by regulation; the transfer of the functions of the former Immigration and Naturalization Service (INS), including the immigration detention authority, to the new DHS in March 2003; the launching of nationality-based detention policies that target asylum seekers from Haiti, Iraq and thirty-one other mostly Arab and Muslim countries; changes in the immigration appeals process; and more restrictive release practices for asylum seekers held in many parts of the country [5]. Since the spring of 2006, both Houses of the US Congress have been debating several immigration reform bills with potentially adverse effects on asylum seekers.

US Asylum Statistics

Each year, tens of thousands of individuals seek asylum in the United States. For the years 2000 through 2004, the US Department of Justice Executive Office for Immigration Review (EOIR) reported that 312,073 applications for asylum were received, about 40% of which were from China (11.6%), Colombia (8.9%), Haiti (7.8%), Mexico (7.8%) and Guatemala (4.0%) [6].

For the years 2000 through 2004, the period of our study, the asylum grant rate (cases approved as a percentage of all cases adjudicated) nationwide was 37.5%. This percentage was derived from two sources: (1) asylum seekers applying affirmatively (which includes an interview at an asylum office, with the potential opportunity to seek legal counsel in advance) through the DHS's US Citizenship and Immigration Service (USCIS) for whom the grant rate was 37.2% [7]; and (2) asylum seekers applying defensively through the EOIR, against whom the U.S. Government has initiated removal proceedings (either because cases were not approved by USCIS or because applicants were apprehended by immigration authorities), for whom the rate was 37.9% [8]. This EOIR percentage includes those initially referred by USCIS, for whom the grant rate was 43.1%, as well as those applying only through EOIR, for whom the grant rate was only 28.6%.

Medical and Psychological Problems among Asylum Seekers

Asylum seekers often suffer from significant physical and mental health consequences as a result of their abuse [9]. Physical manifestations of maltreatment include broken bones, joint and muscle pain, headaches, dizziness, burns and scars, and neurological damage, such as hearing or vision loss and loss of sensation. Psychological and emotional sequelae of difficulties in countries of origin or during the journey to the US may include depression, memory disturbances, difficulty with concentration, lack of energy, social withdrawal, insomnia, flashbacks or phobias [10]. Specific mental health disorders from which survivors of ill-treatment may suffer include Major Depression, Anxiety Disorders, and Posttraumatic Stress Disorder [10].

Physical signs of injury, such as scars or neurological findings, when present, provide important evidence of prior abuse. However, the physical signs of injuries, such as beatings or even burns, may change over time. This is important because most medical evaluations of asylum applicants are conducted a considerable period of time after the alleged abuse. Thus, physical evidence may not be detectable even for the most experienced clinician. Psychological symptoms, on the other hand, when present, are often profound and enduring in nature, and therefore play a critical role in documenting evidence of maltreatment.

Psychological symptoms have been documented frequently among refugee populations [10–12], although they were not associated with grants of asylum in Australia [12]. One study of asylum seekers attending a community clinic found that 35% displayed symptoms of PTSD, while 32.5% exhibited symptoms of major depression [13]. These symptoms can persist over time [14], even a decade later [15]. In a four-country survey of refugees, despite variations in trauma types, conflict-related trauma was associated with PTSD among all populations sampled [16]. Multiple traumatic exposures are associated with greater severity of PTSD among refugee populations [17]. Furthermore, psychiatric co-morbidity has been linked to functional disabilities [18]. Therefore, clinically and legally significant data is lost by not documenting these symptoms among individual asylum seekers.

PHR's Asylum Network

Since 1989, Physicians for Human Rights (PHR), a Nobel Prize winning human rights organization based in Cambridge, Massachusetts, has operated the Asylum Network. The Asylum Network is currently composed of over 500 trained volunteer health professionals nationwide who annually provide approximately 300 medical and psychological evaluations for lawyers representing asylum applicants, in order to objectively assess medical evidence of alleged maltreatment described by applicants before the USCIS and EOIR. Asylum Network members elicit a thorough trauma history; document physical and psychological evidence of abuse and comment on the degree of consistency between examination findings and specific allegations of abuse by the applicant.

PHR's Asylum Network has conducted outreach efforts to law schools and legal aid clinics to make attorneys aware of its activities. A very small number of clients contact PHR directly, having learned of the network from the worldwide web. (Other organizations that provide these evaluations on a more limited basis include Doctors of the World, Survivor International, and various refugee clinics and service agencies).

Roles for Medical and Psychological Evaluations in the Asylum Adjudication Process

Asylum seekers face many preexisting challenges in assembling adequate documentation while fleeing their countries, or in obtaining appropriate, if any, legal counsel upon arrival.

Evaluations completed by physicians, psychologists, and other clinicians are useful in the legal process because they provide adjudicators with evidence on which to base decisions regarding a well founded fear of persecution. Medical evaluations may serve multiple purposes, such as documenting findings consistent with claims of persecution, and thereby supporting a motion to reopen cases that previously lacked forensic documentation. For example, asylum cases may be exempt from the one-year bar because of an evaluation that established that the client suffered from PTSD. Also, psychological evaluations can help to explain to judges a client's flat affect, potentially interpreted as unconvincing, in the context of prior traumas. Furthermore, asylum evaluations may help argue that a person's depression, impaired cognition, or PTSD symptoms prevented him or her from seeking legal counsel within a year of entering the United States. This is particularly useful in cases that are attempting to supercede the procedural bar of the 1996 immigration law that prohibits people from accessing asylum if they have not applied within a year of entering the United States. Finally, affidavits may be helpful in obtaining medical parole for a detained asylum seeker.

Health professionals can also help judges and attorneys understand the effects of trauma on the applicant's behavior, memory, understanding, and demeanor. For example, they can help explain that detention in this country, endured by some asylum seekers, has been shown to exacerbate psychological symptoms associated with torture [19, 20], and may affect their ability to represent themselves as compellingly as possible in court. Indeed, a recent summary of the mental health consequences of deterrence policies urged the medical profession to educate governments and the public about the potential risks of excessively harsh policies of deterrence on the mental health of asylum seekers [21].

Purpose of the Study

The utility of medical evaluations, or even their frequency in the asylum process, has not been previously reported. The purpose of this study was to compare the asylum grant rate among US asylum seekers receiving medical evaluations though the PHR Asylum Network with average national grant rates for asylum and to identify predictors of grant status.

Methods

Study Design and Population

The study included all cases referred to the PHR Asylum Network between January 2000 and December 2004.

Data Collection

The data collected from legal representatives at the time of referral included demographic information (age, sex, country of origin, evaluation location, language spoken) and relevant case information (type of evaluation, hearing dates, lawyer fees). The PHR Asylum Network Coordinator (S.M.) compiled the requisite information necessary for the database through the completion of a one-page questionnaire. In the seven self-referred cases, information was obtained directly from the asylum seeker. Information on a total of 1,663 clients was entered into a Filemaker [22] database.

Training of Evaluators

Clinicians affiliate with PHR's Asylum Network based on their general interest in PHR's activities, or due to word-of-mouth publicity from current clinician evaluators. PHR

provides a training manual that walks people through the process of conducting an evaluation. PHR also offers 4-hour training sessions around the country, which about half of all evaluators have completed. The manual and these training sessions provide a general overview of the legal process, signs and symptoms to look for in the physical and psychological evaluation, and how to structure the written affidavit. PHR also runs a mentoring program that matches new evaluators with more seasoned ones. In the vast majority of cases, evaluations proceed smoothly, although burn-out among evaluators with several open cases, has, very occasionally, led to tensions between clinicians and attorneys. For this reason, PHR attempts to distribute new cases equitably.

Intervention

After intake information was entered, clients were matched with a volunteer health professional. Matching considerations included the type of evaluation, location, gender of the PHR volunteer and client, languages spoken by the PHR volunteer and client, and whether the legal representation was *pro bono*.

After the client was matched with an evaluator, an evaluation was conducted, which typically consisted of a psychosocial history, past medical history, description of maltreatment, and, when applicable, a summary of detention and abuse, circumstances of detention, and prison/detention conditions. Asylum status, when available, was obtained from clients' attorneys, by the Network Coordinator.

Statistical Analysis

Descriptive statistics of demographics and asylum grant rates are reported. Pearson chi square tests were used to elicit differences in evaluation outcomes (granted versus denied) across variables of interest. We also attempted to estimate and test a logistic regression model to assess which variables contributed independently to asylum grant rates. As this is largely un-researched territory we did not want to miss possibly important differences so no correction for multiple testing was used. SAS version 9.1 was used for calculations.

Ethical Considerations of Human Subjects Research

To ensure protection of human subjects the research protocol was reviewed and approved by PHR's Ethics Review Board, which is an independent group of individuals with expertise in clinical medicine, public health, bioethics, and international human rights research conducted in accord with the Declaration of Helsinki, as revised in 2000 [23].

Results

A total of 1,663 records were obtained between 2000 and 2004. Records from 2005 were not used because asylum grant rates would not consistently be available during the period of study. Of these 1,663 records, 459 were not completely evaluated because either: (1) the clinician declined to evaluate the case; (2) the case was never placed by the coordinator; (3) the lawyer was not reachable; (4) the lawyer withdrew from the case; or (5) the case was not an asylum application. These cases were not included in the analysis. The remaining 1,204 asylum seekers all received evaluations from PHR and the asylum (or withholding from removal) status (either granted or denied) has been determined in 746 (62%) of these cases while 458 (38%) of these cases were still pending.

Characteristics of the Study Population

Table 1 includes records from the years 2000–2004 and shows referral year, continent of origin, age range, gender, English language ability, presence of oral testimony, evaluation type, city of medical evaluation, legal fees charged, and asylum grant rates.

Asylum Grant Rate

Table 1 shows the frequencies of demographic variables. Of the 746 asylum seekers with a determined asylum or withholding from removal status, 89.0% (664/746) were granted asylum or withholding from removal (herein referred to simply as asylum because both allow the recipient to remain in the US, and all but 17 of the 664 received asylum specifically), compared with the national average of approximately 37.5% among US asylum seekers.

Table 2 shows grant rates for each of the demographic variables. Having been detained in the United States was associated with denials (Pearson chi square = 38.85, $P < 0.0001$). Also, asylum seekers who were represented by *pro bono* legal advocates were more likely to be granted asylum than those who were charged for legal representation (Pearson chi square = 8.4, $P = 0.01$). Upon further inspection, we noted that fees, either reduced or full, were associated with denials in a linear fashion (Cochran-Armitage test for trend $P = .0037$). Other variables, such as age, sex, country of origin, English language ability, and geographic location of the evaluation (other than a detention center), were not associated with the asylum grant rate.

We unsuccessfully attempted to estimate a logistic regression model to determine which of the measured variables were significantly related to the dependent variable of interest, asylum granted versus not. As independent variables we used demographic information (age, sex,

Table 1 Demographic characteristics of asylum seekers through PHR (2000–2004)

Variable		*N* (%)* $
Year	2004	257 (21.3)
	2003	265 (22)
	2002	235 (19.5)
	2001	248 (20.6)
	2000	199 (16.5)
	All	1204 (99.9)
Continent	Africa	677 (56.3)
	Asia	222 (18.5)
	Europe	133 (11.1)
	Americas	128 (10.6)
	Middle East	42 (3.5)
	All	1202 (100)
Age range	Under 21	86 (7.4)
	21–30	446 (38.6)
	31–40	412 (35.6)
	41–50	155 (13.4)
	Over 50	47 (4.9)
	All	1156 (99.9)
Gender	Male	659 (54.9)
	Female	540 (45)
	All	1199 (99.9)
Language	No english	673 (57.1)
	English	496 (42.1)
	Some english	10 (0.8)
	All	1179 (100)
Oral testimony	No	677 (52)
	Yes	624 (48)
	All	1301(100)
Eval type	Psych	613 (51.6)
	Med	519 (43.7)
	Gyn	47 (4)
	Other	10 (0.8)
	All	1189 (100.1)
City	NYC/NJ	460 (38.3)
	Boston	228 (19)
	DC/Baltimore	224 (18.7
	Other	192 (16)
	Detained (all cities)	97 (8.1)
	All	1201 (100.1)
Fee	ProBono	691 (64.2)
	Reduced	257 (23.9)
	Profit	127 (11.8)
	All	1076 (99.9)
Asylum granted	Yes	664 (89)
	No	82 (11)
	All	746 (100)

* Totals may not equal 100% due to rounding

$ Number of cases varies for each variable due to missing data.

Table 2 Demographic characteristics by asylum status (2000–2004)

Variable		Granted *N* (%)	Denied *N* (%)	Total[****] [$]
Year	2004	74 (92.5)	6 (7.5)	80 (99.9)
	2003	123 (91.1)	12 (8.9)	135 (100)
	2002[*]	143 (82.2)	31 (17.8)	174 (100)
	2001	178 (88.6)	23 (11.4)	201 (100)
	2000	146 (93.6)	10 (6.4)	156 (100)
	All			746
Continent	Africa	364 (89.2)	44 (10.8)	408 (100)
	Asia	137 (90.7)	14 (9.2)	151 (99.9)
	Europe	77 (88.5)	10 (11.5)	87 (99.9)
	Americas	62 (86.1)	10 (13.9)	72 (100)
	MidEast	23 (85.2)	4 (14.8)	27 (100)
	All			745
Age range	Under 21	49 (84.5)	9 (15.5)	58 (100)
	21–30	248 (87.9)	34 (12.1)	282 (100)
	31–40	229 (93.9)	15 (6.1)	244 (100)
	41–50	85 (87.6)	12 (12.4)	97 (100)
	Over 50	29 (90.6)	3 (9.4)	32 (100)
	All			693
Gender	Male	353 (87.2)	52 (12.8)	405 (100)
	Female	308 (91.1)	30 (8.9)	338 (100)
	All			743
Language	No english	394 (90)	44 (10)	438 (100)
	English	270 (87.7)	38 (12.3)	308 (100)
	All			746
Oral testimony	No	261 (89.4)	31 (10.6)	292 (100)
	Yes	243 (85.9)	40 (14.1)	283 (100)
	All			575
Eval type	Psych	385 (89.8)	38 (10.2)	373 (100)
	Med	288 (87.5)	41 (12.5)	329 (100)
	Gyn	23 (88.6)	3 (11.5)	26 (100.1)
	Other	4 (100)	0	4 (100)
	All			732
City	NYC/NJ	259 (92.1)	22 (7.8)	281 (99.9)
	Boston	110 (94.8)	6 (5.1)	116 (99.9)
	DC/Baltimore	138 (91.4)	13 (8.6)	151 (100)
	Philadelphia	25 (89.3)	3 (10.7)	28 (100)
	Other	72 (84.7)	13 (15.3)	85 (100)
	Detained (in any city)[**]	60 (70.6)	25 (29.4)	85 (100)
	All			746
Fee	ProBono	378 (90.4)	40 (9.6)	418 (100)
	Reduced	129 (87.2)	19 (12.8)	148 (100)
	For profit[***]	55 (78.6)	15 (21.4)	70 (100)
	All			636

[*] 2002 versus other years, Chi-Square 13.278, $P = 0.01$

[**] Detained versus non-detained, Chi-Square 13.278, $P = 0.01$

[***] For Profit versus ProBono and Reduced, Chi-Square 8.473, $P = 0.0145$

[****] Totals may not equal 100% due to rounding

[$] Number of cases varies for each variable due to missing data

country of origin, evaluation location, language spoken) and relevant case information (type of evaluation, hearing dates, lawyer fees) used in the univariate comparisons. A warning indicated, however, that the maximum likelihood solution may not exist due to a possibly complete separation of the outcome as spread among the groups. That is, when cross-classified by the independent variables, some cells were empty. This may be due in part to the restricted sample size. Therefore, our data is best understood with descriptive statistics and chi square tests.

Data were also available from cases between 1996 and 1999. However, they were not included in the primary analysis as two of the measures of interest, fee status and oral testimony status, were not recorded prior to 2000. Comparisons of demographic variables indicated no significant differences in between these cases and those in the primary analysis. Comparisons parallel to those described which included this pre-2000 data, minus the two missing variables, were conducted. No differences in the substantive results were found.

Discussion

Future Role of Medical Evaluations in Asylum Cases

This study demonstrates that asylum seekers in the United States who received medical evaluations have higher asylum grant rates (89%) than the national average of 37.5% during the same period. Although there is no way to know what the grant rate among PHR's clientele would be without these medical evaluations, given the robustness of these findings, it is arguable that medical evaluations made a difference in a significant number of cases. This finding is important not only for those individuals whose lives are affected by their asylum status but also for the asylum process as a whole. It raises the question of whether medical evaluations should be standard, or if all asylum seekers should have the right to a medical evaluation during the adjudication process. The grant rate among recipients of evaluations also begs the question about whether the standard of proof will change if medical evaluations become more commonplace, i.e., will immigration officials come to expect medical and psychological evaluations, without which legal defenses will be perceived as less compelling.

Role of Legal Representation in Asylum Case Outcomes

This study also demonstrates an association between a history of detention and denial of asylum. This may reflect the differences in the asylum process for those in detention. Under current US law (the Illegal Immigration Reform and Immigrant Responsibility Act, 1996), the Bureau of Immigration and Customs Enforcement (BICE) arm of the DHS is required to detain asylum seekers who arrive in the US without the required travel documents. Thus, many asylum seekers in detention are those who asked for asylum at the border and were then detained. These applicants would not have had the opportunity to go through the so-called ''affirmative asylum process,'' that includes an interview at an asylum office, with the potential opportunity to seek legal counsel in advance. Many applicants applying at the border through this ''defensive process'', without an attorney present, make statements at the border that can be used against them later. These ''administrative detainees'' are not criminal detainees; nevertheless, they are held in jail cells alongside convicted criminal inmates [24], and may be perceived unworthy of asylum in part due to their history of detention. Indeed, asylum seekers arriving in the US may be held in detention for months or years while awaiting adjudication of their asylum claims [25]. In this study sample, a few applicants in detention may have a prior history of criminal activity that may predispose judges to deny asylum claims; however, PHR did not knowingly accept any cases with such a history, so criminal history is probably not a confounder among cases reported on here. Another outcome among those detained is a ''definitive denial'' (voluntary departure without appeal) because of the hardship of detention.

Also relevant was the presence of legal representation among virtually all applicants with medical evaluations from PHR, because only a minority of applicants nationwide have legal representation; only 31% of 223,955 affirmative applicants with cases adjudicated from 2000 through 2003 had legal representation [26]. An obvious question is the extent to which the asylum grant rate in our sample is attributable to the medical evaluation as opposed to the legal representation. However, of the aforementioned affirmative applicants, grant rates ranged from 24% (those with no legal representation) to 41% (those with legal representation) [26]. Among cases in expedited removal proceedings, grant rates ranged from 2% (those with no legal representation) to 25% (those with legal representation) [26]. These rates are even lower than the 37.9% grant rate reported above because the denominator includes cases referred, cases closed for various reasons, and cases marked as no show. Most importantly, the grant rate with medical evaluations still far surpasses the rates with legal representation alone, regardless of whichever legal process adjudicates the case.

Geographic Considerations in the Asylum Process

A theoretical confounder could be the geographic location where detainees' cases were adjudicated. If cases were heard in states with higher asylum denial rates, this could raise the denial rates among detainees in this sample. Indeed, detention centers, and hence the hearings of detainees, were located in the Northeastern states where denial rates were higher (and grant rates lower: NY, 18%; NJ, 23%; PA, 19%) than the overall national average [27]. Despite national variations in grant rates, the grant rate among evaluation recipients from those states were

comparable (NY and NJ, 92.1% (259/281); PA, 89.3% (25/28)) to the average rate of 89%, so the overall confounding effect is likely small in relation to the overall impact of medical evaluations on grant rates.

Another factor to consider is refugees' country of origin, because asylum rates vary considerably according to nationality. The nationalities in our sample of asylum seekers, the majority of whom were from African countries, are not representative of asylum seekers nationwide. Nationwide, if the substantial number of applicants from China, Haiti, and Central American countries were to receive asylum at a low rate, it could certainly decrease the national asylum grant rate overall compared to grant rates among our sample. However, during the 2000–2004 study period, nationwide, asylum rates among applicants from Haiti and China were among the highest (Haiti: 42.9% and China 39%). Guatemala and Mexico did have lower national asylum grant rates (Guatemala: 15% and Mexcio: 9.1%) [28]; however, the grant rates among PHR's asylum seekers from Guatemala and Mexico were considerably higher (Guatemala: 67% and Mexico: 100%) all of which suggests that nationality as a variable in our sample, compared to its distribution among all asylum seekers, is not a major cause of the difference in grant rates among recipients of medical evaluations and legal assistance compared to the national average.

Association between Higher Fees Paid for Legal Representation and Denial of Asylum Claims

We found a linear relationship between fee paid and asylum denials; grant rates for pro bono, reduced fee, and full-fee were 90.4% (378/418), 87.2% (129/148), and 78.6% (55/70) respectively. One possible explanation is that the sources of referrals to PHR (largely legal aid organizations with long waitlists for *pro bono* representation) might take on cases that they perceive as having a higher likelihood of successful adjudication. While this may also explain in part the very high rates of asylum overall, not all cases were referred by *pro bono* agencies (384 cases were not *pro bono*), and even rates of full-fee cases, which in general presented to PHR because attorneys knew of this service, were still much higher (78.6%) than the national average.

Strengths and Limitations of the Study

To our knowledge, this is the first study to report asylum grant rates in the US among recipients of medical evaluations, and to document the considerable difference in those rates compared to nationwide rates among applicants who generally do not receive medical documentation of maltreatment and legal assistance.

The generalizability of the findings of the study may be limited by a number of factors. First, comparisons of asylum granting rates were limited to national averages and the proportion of asylum applicants receiving medical evaluations nationally is not known, although it is likely small. Secondly, all cases reported here received legal representation, compared to 31% among the national average of affirmative cases, and such legal representation is also a predictor of asylum grants (although not definitive; as noted earlier, 59% of affirmative cases with legal representation were denied asylum). Thirdly, there may be a referral bias in favor of more egregious cases, with a suspected history of maltreatment, in PHR's database, which may have contributed to a higher rate of asylum approvals than the national average. The percentage of cases nationally with a history of maltreatment is not known (and is not tracked), and our sample may not be representative. Fourthly, the national asylum grant rate may include an unknown number of cases where criminal behavior was a cause of denial, whereas such cases were not knowingly taken on by PHR. Fifthly, evaluators who volunteer for PHR, by virtue of their interest in the asylum process, may be more likely than other evaluators to find evidence of maltreatment, although they are instructed never to document evidence they do not find credible. Finally, regional variations in the US regarding granting decisions, or perhaps refugees' nationalities, or may have affected our results.

Conclusion

In our study, 89% of asylum seekers in the US who received medical documentation of symptoms by PHR, as well as legal assistance, received asylum, compared to the national average of 37.5% who receive asylum. Health professionals can often provide critical documentation of maltreatment that may be crucial in an asylum proceeding [29]. Medical-legal documentation of maltreatment requires a careful clinical history and examination by a health professional who is sensitive to cross-cultural issues and interpersonal dynamics between traumatized individuals and persons in positions of authority [28]. The examiner should also be knowledgeable about the medical and psychosocial consequences of maltreatment and torture [10, 28–32] and the established guidelines for effective documentation [10, 28, 31].

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